FRAMEWORK FOR STATE EVALUATION OF CHILDREN'S HEALTH INSURANCE PLANS UNDER TITLE XXI OF THE SOCIAL SECURITY ACT

(Developed by States, for States to meet requirements under Section 2108(b) of the Social Security Act)

State/Territory: **Minnesota**

(Name of State/Territory)

The following State Evaluation is submitted in compliance with Title XXI of the Social Security Act (Section 2108(b)).

(Signature of Agency Head)

Date

Reporting Period **October 1, 1998 to September 30, 1999**

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SECTION 1. SUMMARY OF KEY ACCOMPLISHMENTS OF YOUR CHIP PROGRAM

This section is designed to highlight the key accomplishments of your CHIP program to date toward increasing the number of children with creditable health coverage (Section 2108(b)(1)(A)). This section also identifies strategic objectives, performance goals, and performance measures for the CHIP program(s), as well as progress and barriers toward meeting those goals. More detailed analysis of program effectiveness in reducing the number of uninsured low-income children is given in sections that follow.

1.1 What is the estimated baseline number of uncovered low-income children? Is this estimated baseline the same number submitted to HCFA in the 1998 annual report? If not, what estimate did you submit, and why is it different?

We did not submit a 1998 annual report, since our S-CHIP expansion had just become effective in September of 1998. Our estimated baseline number of uncovered low-income children is 30. At the time we submitted the state plan, we estimated that there were only 1,500 statewide who were between ages 0 to 2 and who were in families with incomes that fell between 275% and 280% of the federal poverty guidelines. We then estimated that two percent of those 1,500 children were uninsured, and that one percent, or 15 children, would enroll in this program.

1.1.1 What are the data source(s) and methodology used to make this estimate?

We used the Current Population Survey (CPS) to determine the number of children in that age range and income range.

1.1.2 What is the State's assessment of the reliability of the baseline estimate? What are the limitations of the data or estimation methodology? (Please provide a numerical range or confidence intervals if available.)

Our estimate is confirmed by experience in FFY 1999.

1.2 How much progress has been made in increasing the number of children with creditable health coverage (for example, changes in uninsured rates, Title XXI enrollment levels, estimates of children enrolled in Medicaid as a result of Title XXI outreach, anti-crowd-out efforts)? How many more children have creditable coverage following the implementation of Title XXI? (Section

2108(b)(1)(A))

For FFY 99, we had 19 children enrolled. We estimate that no new Medicaid enrollment occurred specifically because of S-CHIP related outreach. All of our outreach efforts are directed at the Medical Assistance and MinnesotaCare Programs. The S-CHIP expansion population is a very narrow category in the Medical Assistance Program.

1.2.1 What are the data source(s) and methodology used to make this estimate?

N/A

1.2.2 What is the State's assessment of the reliability of the estimate? What are the limitations of the data or estimation methodology? (Please provide a numerical range or confidence intervals if available.)

N/A

1.3 What progress has been made to achieve the State's strategic objectives and performance goals for its CHIP program(s)?

Please complete Table 1.3 to summarize your State's strategic objectives, performance goals, performance measures and progress towards meeting goals, as specified in the Title XXI State Plan. Be as specific and detailed as possible. Use additional pages as necessary. The table should be completed as follows:

Column 1: List the State's strategic objectives for the CHIP program, as specified in the State Plan.

Column 2: List the performance goals for each strategic objective.

Column 3: For each performance goal, indicate how performance is being measured, and progress towards meeting the goal. Specify data sources, methodology, and specific measurement approaches (e.g., numerator, denominator). Please attach additional narrative if necessary.

For each performance goal specified in Table 1.3, please provide additional narrative discussing how actual performance to date compares against performance goals. Please be as specific as possible concerning your findings to date. If performance goals have not been met, indicate the barriers or constraints. The narrative also should discuss future performance measurement activities, including a projection of when additional data are likely to be available.

Table 1.3

(1) Strategic Objectives (as specified in Title XXI State Plan)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify data sources, methodology, numerators, denominators, etc.)
OBJECTIVES RELATED TO REDUCING THE NUMBER OF UNINSURED CHILDREN		
Expand Access to health care insurance for uninsured infants	**Reduce the number of uninsured children in Minnesota by enrolling low-income children under age 2 in the Medicaid program with income above 275% but equal to or less than 280% of FPG.**	Data Sources: **MMIS** Methodology: Numerator: Denominator: Progress Summary: **Nineteen children were enrolled in this category during FFY 1999. The current rate of uninsurance among children under age 19 in Minnesota is 3.7%. Nineteen children would not have affected this rate.**
OBJECTIVES RELATED TO CHIP ENROLLMENT		

Table 1.3		
(1) Strategic Objectives (as specified in Title XXI State Plan)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify data sources, methodology, numerators, denominators, etc.)
		Data Sources: Methodology: Numerator: Denominator: Progress Summary:
OBJECTIVES RELATED TO INCREASING MEDICAID ENROLLMENT		
		Data Sources: Methodology: Numerator: Denominator: Progress Summary:

Table 1.3		
(1) Strategic Objectives (as specified in Title XXI State Plan)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify data sources, methodology, numerators, denominators, etc.)
OBJECTIVES RELATED TO INCREASING ACCESS TO CARE (USUAL SOURCE OF CARE, UNMET NEED)		
		Data Sources: Methodology: Numerator: Denominator: Progress Summary:
OBJECTIVES RELATED TO USE OF PREVENTIVE CARE (IMMUNIZATIONS, WELL-CHILD CARE)		
		Data Sources: Methodology: Numerator: Denominator: Progress Summary:

OTHER OBJECTIVES		
		Data Sources: Methodology: Numerator: Denominator: Progress Summary:

SECTION 2. BACKGROUND

This section is designed to provide background information on CHIP program(s) funded through Title XXI.

2.1 How are Title XXI funds being used in your State?

2.1.1 List all programs in your State that are funded through Title XXI. (Check all that apply.)

_**x**_ Providing expanded eligibility under the State's Medicaid plan (Medicaid CHIP expansion)

Name of program: **Minnesota Medical Assistance Program**

Date enrollment began (i.e., when children first became eligible to receive services): **September 30, 1998**

___ Obtaining coverage that meets the requirements for a State Child Health Insurance Plan (State-designed CHIP program)

Name of program: _____

Date enrollment began (i.e., when children first became eligible to receive services): _____

___ Other - Family Coverage

Name of program: _____

Date enrollment began (i.e., when children first became eligible to receive services): _____

___ Other - Employer-sponsored Insurance Coverage

Name of program: _____

Date enrollment began (i.e., when children first became eligible to receive services): _____

___ Other - Wraparound Benefit Package

Name of program: _____

Date enrollment began (i.e., when children first became eligible to receive services): _____

___ Other (specify) _____

Name of program: _____

Date enrollment began (i.e., when children first became eligible to receive services): _____

2.1.2 **If State offers family coverage:** Please provide a brief narrative about requirements for participation in this program and how this program is coordinated with other CHIP programs.

N/A

2.1.3 **If State has a buy-in program for employer-sponsored insurance:** Please provide a brief narrative about requirements for participation in this program and how this program is coordinated with other CHIP programs.

N/A

2.2 What environmental factors in your State affect your CHIP program? (Section 2108(b)(1)(E))

2.2.1 How did pre-existing programs (including Medicaid) affect the design of your CHIP program(s)?

The Minnesota Medical Assistance Program is the "regular" Medicaid program in Minnesota. In that program, children under age two are eligible if family income is below 280% of the federal poverty guidelines. Children age two through five are eligible at 133% of federal poverty. Children age 6 to 17 born after 10/1/83 are eligible at 100% of federal poverty. Children born before 10/1/83 eligible at 133% of the AFDC standard, which is roughly 65% of federal poverty. There is no asset test for children in this program.

The MinnesotaCare program is an 1115 waiver expansion program. It covers all children under age 21, and their parents or related caretakers with income below 275% of federal poverty. The income standard for pregnant women is also 275% of poverty. Adults without children are eligible for this program with income below 175% of poverty. Families are required to pay a monthly premium. There

are some copayments and benefit limits for adults enrolled in the program. The benefit package for children is the same as the Medical Assistance Program for children.

The existence of the MinnesotaCare program greatly affected the design of our S-CHIP program. Title XXI defines an eligible child as one who is not eligible for existing Medicaid coverage (which includes Medical Assistance and MinnesotaCare). Our only option to expand coverage consistently with the S-CHIP rules would have been to raise the MinnesotaCare income standard from 275% anywhere up to 325% of poverty. Since we have 48,000 uninsured children under age 19 in this state, two-thirds of whom are in families with income below 200% of poverty, despite the existing high income standards in MinnesotaCare, it did not make sense to raise the income standard in an effort to reduce the rate of uninsurance among children.

The result is that we have a tiny S-CHIP program that was designed as a method to ensure that Minnesota's allotment was not reallocated for efforts in other states, until we had an opportunity to develop strategies in the alternative to increasing the income standard. To that end, Governor Ventura submitted a new §1115 waiver request the week of March 27th to the Health Care Financing Administration.

2.2.2 Were any of the preexisting programs "State-only" and if so what has happened to that program?

___ No pre-existing programs were "State-only"

_x_ One or more pre-existing programs were "State only" ! Describe current status of program(s): Is it still enrolling children? What is its target group? Was it folded into CHIP?

The General Assistance Medical Care Program (GAMC) is a health care program funded entirely by a State general fund appropriation. It is designed to cover those individuals who do not meet the categorical eligibility requirements in Medicaid. It primarily serves adults who do not meet disability requirements, but it does have roughly 600 children enrolled because they do not meet the citizenship requirements of the Medicaid Program. It is important to note that states cannot effectively cover all children because of those citizenship barriers. GAMC was not changed as a result of S-CHIP.

A portion of the MinnesotaCare Program is funded with 100% state funding. Adults in families without children are eligible for the program (below 175% FPG) but are not covered by the 1115 waiver.

2.2.3 Describe changes and trends in the State since implementation of your Title XXI program that "affect the provision of accessible, affordable, quality health insurance and healthcare for children." (Section 2108(b)(1)(E))

Examples are listed below. Check all that apply and provide descriptive narrative if applicable. Please indicate source of information (e.g., news account, evaluation study) and, where available, provide quantitative measures about the effects on your CHIP program.

_**x**_ Changes to the Medicaid program

___ Presumptive eligibility for children
___ Coverage of Supplemental Security Income (SSI) children
___ Provision of continuous coverage (specify number of months ___)
___ Elimination of assets tests
_**x**_ Elimination of face-to-face eligibility interviews
_**x**_ Easing of documentation requirements

___ Impact of welfare reform on Medicaid enrollment and changes to AFDC/TANF (specify)**_We know that enrollment in MA has been flat for the last several years. Enrollment in MinnesotaCare continues to grow, but at a slower pace than was true in earlier years. We have not seen the kind of drop in Medicaid enrollment that has occurred in other states. We believe that the slowing down of the growth in enrollment has more to do with the strong economy and low unemployment rate than with welfare reform.**

x___ Changes in the private insurance market that could affect affordability of or accessibility to private health insurance

_**x**_ Health insurance premium rate increases
___ Legal or regulatory changes related to insurance
___ Changes in insurance carrier participation (e.g., new carriers entering market or existing carriers exiting market)
_**x**_ Changes in employee cost-sharing for insurance
___ Availability of subsidies for adult coverage
___ Other (specify) _____

___ Changes in the delivery system

___ Changes in extent of managed care penetration (e.g., changes in HMO, IPA, PPO activity)
___ Changes in hospital marketplace (e.g., closure, conversion, merger)

___ Other (specify) _____

___ Development of new health care programs or services for targeted low-income children (specify) _____

_**x**_ Changes in the demographic or socioeconomic context

___ Changes in population characteristics, such as racial/ethnic mix or immigrant status (specify) **racial and ethnic minorities make up an increasing percentage of Minnesota's uninsured population, but that trend is not specific to the one year that the S-CHIP expansion has been in effect.**

_x__ Changes in economic circumstances, such as unemployment rate (specify) **The unemployment rate has been falling and the median income has been rising for the last several years.**

___ Other (specify)_____

___ Other (specify) _____

SECTION 3. PROGRAM DESIGN

This section is designed to provide a description of the elements of your State Plan, including eligibility, benefits, delivery system, cost-sharing, outreach, coordination with other programs, and anti-crowd-out provisions.

3.1 Who is eligible?

3.1.1 Describe the standards used to determine eligibility of targeted low-income children for child health assistance under the plan. For each standard, describe the criteria used to apply the standard. If not applicable, enter "NA."

Table 3.1.1

	Medicaid CHIP Expansion Program	**State-designed CHIP Program**	**Other CHIP Program*** _____
Geographic area served by the plan (Section 2108(b)(1)(B)(iv))	**Statewide**		
Age	**0-2**		
Income (define countable income)	**> 275% FPG and # 280% FPG.****		
Resources (including any standards relating to spend downs and disposition of resources)	**NA**		
Residency requirements	**State resident**		
Disability status	**NA**		
Access to or coverage under other health coverage (Section 2108(b)(1)(B)(i))	**Applicants and enrollees must enroll in cost-effective insurance**		
Other standards (identify and describe)_____	**NA**		

*Make a separate column for each "other" program identified in Section 2.1.1. To add a column to a table, right click on the mouse, select "insert" and choose "column".

****countable income is defined as all non-excluded earned and unearned income with the following**

deductions and disregards: a standard work expense deduction; child care expenses; and $50 child support deduction. See Tables 3.1.1.4 and 3.1.1.5.

Addendum to Table 3.1.1

The following questions and tables are designed to assist states in reporting countable income levels for their Medicaid and SCHIP programs and included in the NASHP SCHIP Evaluation Framework (Table 3.1.1). This technical assistance document is intended to help states present this extremely complex information in a structured format.

The questions below ask for countable income levels for your Title XXI programs (Medicaid SCHIP expansion and State-designed SCHIP program), as well as for the Title XIX child poverty-related groups. Please report your eligibility criteria as of **September 30, 1999.** Also, if the rules are the same for each program, we ask that you enter duplicate information in each column to facilitate analysis across states and across programs.

If you have not completed the Medicaid (Title XIX) portion for the following information and have passed it along to Medicaid, please check here **9** and indicate who you passed it along to. Name_____, phone/email_____

3.1.1.1 For each program, do you use a gross income test or a net income test or both?

Title XIX Child Poverty-related Groups	____Gross	__X_Net	____Both
Title XXI Medicaid SCHIP Expansion	____Gross	__X_Net	____Both
Title XXI State-Designed SCHIP Program	____Gross	____Net	____Both
Other SCHIP program_____	____Gross	____Net	____Both

3.1.1.2 What was the income standard or threshold, as a percentage of the Federal poverty level, for countable income for each group? If the threshold varies by the child's age (or date of birth), then report each threshold for each age group separately.

Title XIX Child Poverty-related Groups	_133% of FPL for children under age _2 through 5_
	_100% of FPL for children aged _6 and older, born after 9/30/83
	_275 % of FPL for children aged _0 - 2_____
Title XXI Medicaid SCHIP Expansion	_280 % of FPL for children aged _0 - 2_____
	____% of FPL for children aged _____
	____% of FPL for children aged _____
Title XXI State-Designed SCHIP Program	____% of FPL for children aged _____
	____% of FPL for children aged _____
	____% of FPL for children aged _____
Other SCHIP program_____	____% of FPL for children aged _____
	____% of FPL for children aged _____

____% of FPL for children aged _____

3.1.1.3 Complete Table 1.1.1.3 to show whose income you count when determining eligibility for each program and which household members are counted when determining eligibility? (In households with multiple family units, refer to unit with applicant child)

Enter "Y" for yes, "N" for no, or "D" if it depends on the individual circumstances of the case.

Table 3.1.1.3

Family Composition	Title XIX Child Poverty-related Groups	Title XXI Medicaid SCHIP Expansion	Title XXI State-designed SCHIP Program	Other SCHIP Program* _____
Child, siblings, and legally responsible adults living in the household *	Y	Y		
All relatives living in the household	N	N		
All individuals living in the household	N	N		
Other (specify)				

* Note: Siblings, stepparents and step-siblings are included in the household size determination. But income of these individuals is not considered in determining countable income of applicant child in a poverty level or SCHIP income group. (Income deeming (financial responsibility) under Title XIX only occurs between spouses, and parents and children.)

3.1.1.4 How do you define countable income? For each type of income please indicate whether it is counted, not counted or not recorded.

Enter "C" for counted, "NC" for not counted and "NR" for not recorded.

Table 3.1.1.4

Type of Income	Title XIX Child Poverty-related Groups	Title XXI Medicaid SCHIP Expansion	Title XXI State-designed SCHIP Program	Other SCHIP Program* _____
Earnings Earnings of dependent children	C (if not a full or part-time student)	C (if not a full or part-time student)		
Earnings of students	NC (dependent child)	NC (dependent child)		

Type of Income	Title XIX Child Poverty-related Groups	Title XXI Medicaid SCHIP Expansion	Title XXI State-designed SCHIP Program	Other SCHIP Program* _____
Earnings from job placement programs	NC (dependent child)	NC (dependent child)		
Earnings from community service programs under Title I of the National and Community Service Act of 1990 (e.g., Serve America)	C	C		
Earnings from volunteer programs under the Domestic Volunteer Service Act of 1973 (e.g., AmeriCorps, Vista))	NC (except AmeriCorps living allowances)	NC (except AmeriCorps living allowances)		
Education Related Income Income from college work-study programs	NC (under-graduate only)	NC (under-graduate only)		
Assistance from programs administered by the Department of Education	NC (under-graduate only)	NC (under-graduate only)		
Education loans and awards	NC (under-graduate only)	NC (under-graduate only)		
Earned income tax credit (EITC)	NC	NC		
Alimony payments received	C	C		
Child support payments received	C	C		
Roomer/boarder income	C	C		
Income from individual development accounts	C	C		
Gifts (if regular, or over $30)	C	C		
In-kind income	NC	NC		
Program Benefits Welfare cash benefits (TANF)	NC	NC		
Supplemental Security Income (SSI) cash benefits	NC	NC		
Social Security cash benefit	C	C		
Housing subsidies	NC	NC		
Foster care cash benefits	NC	NC		
Adoption assistance cash benefits	NC	NC		
Veterans benefits	C	C		
Emergency or disaster relief benefits	NC	NC		
Low income energy assistance payments	NC	NC		
Native American tribal benefits	C	C		
Other Types of Income (specify)				

Type of Income	Title XIX Child Poverty-related Groups	Title XXI Medicaid SCHIP Expansion	Title XXI State-designed SCHIP Program	Other SCHIP Program* _____
Self-employment	C	C		
Rental income	C	C		
Farm income	C	C		
Workers' Compensation	C	C		
Reemployment Insurance	C	C		
Retroactive lump sum SSI (& RSDI of SSI recipient)	NC	NC		
Retroactive lump sum RSDI	C	C		
Interest & Dividends	C	C		
Lump sums (income in month received, then asset)	C	C		

*Make a separate column for each "other" program identified in Section 2.1.1. To add a column to a table, right click on the mouse, select "insert" and choose "column".

3.1.1.5 What types and *amounts* of disregards and deductions does each program use to arrive at total countable income?

Please indicate the amount of disregard or deduction used when determining eligibility for each program. If not applicable, enter "NA."

Do rules differ for applicants and recipients (or between initial enrollment and redetermination)
____ Yes __X__ No

If yes, please report rules for applicants (init-al enrollment).

Table 3.1.1.5

Type of Disregard/Deduction	Title XIX Child Poverty-related Groups	Title XXI Medicaid SCHIP Expansion	Title XXI State-designed SCHIP Program	Other SCHIP Program* _____
Earnings: Age 2 and older: $90 + $30 + 1/3 of remaining income according to AFDC cycle Birth to age 2: standard work incentive disregard by family size	$ varies w/ income $ 140 (family of 2)	$ varies w/ income $140 (family of 2)	$	$

Type of Disregard/Deduction	Title XIX Child Poverty-related Groups	Title XXI Medicaid SCHIP Expansion	Title XXI State-designed SCHIP Program	Other SCHIP Program* _____
Self-employment expenses, general: IRS-allowed deductions, except NOL, depreciation, retirement contributions, charitable deductions, capital expenditures, payments on principal balance of loans.	case specific	case specific	$	$
Alimony payments				
Received	$ 0	$ 0	$	$
Paid	$	$	$	$
Child support payments				
Received	$ 50	$ 50	$	$
Paid	$	$	$	$
Child care expenses ($200, if child under age 2)	$ 175/child	$ 175/child	$	$
Medical care expenses (medically needy category only)	$ 0	$ 0	$	$
Gifts - if irregular and $30 or less	$ 30	$ 30	$	$
Other types of disregards/deductions (specify):				
Self-employment, in-home day care, alternative to itemized	60% of gross receipts	60% of gross receipts		
Self-employment, home office costs for portion of home used	case specific	case specific		
Self-employment, transportation @ IRS mileage rate	case specific	case specific		
Self-employment, rental income: greater of $103/yr. or 2% of estimated market value	case specific	case specific		
Self-employment, room & board: Roomer Boarder R & B	$71/mo $127/mo $198/mo	$ 71/mo $ 127/mo $ 198/mo		
Self-employment, farm income: all expenses associated with producing income, with add-backs noted above in self-employment	case specific	case specific		

*Make a separate column for each "other" program identified in Section 2.1.1. To add a column to a table, right click on the mouse, select "insert" and choose "column".

3.1.1.6 For each program, do you use an asset or resource test?

Title XIX Poverty-related Groups	__X__ No	____Yes (complete column A in 3.1.1.7)
Title XXI SCHIP Expansion program	_X_ No	____Yes (complete column B in 3.1.1.7)
Title XXI State-Designed SCHIP program	____No	____Yes (complete column C in 3.1.1.7)
Other SCHIP program_____	____No	____Yes (complete column D in 3.1.1.7)

3.1.1.7 How do you treat assets/resources?

Please indicate the countable or allowable level for the asset/resource test for each program and describe the disregard for vehicles. If not applicable, enter "NA."

Table 3.1.1.7 Treatment of Assets/Resources	Title XIX Child Poverty-related Groups (A)	Title XXI Medicaid SCHIP Expansion (B)	Title XXI State-designed SCHIP Program (C)	Other SCHIP Program* [redacted] (D)
Countable or allowable level of asset/resource test	$ N/A	$ N/A	$	$
Treatment of vehicles: Are one or more vehicles disregarded? *Yes or No*	N/A	N/A		
What is the value of the disregard for vehicles?	$ N/A	$ N/A	$	$
When the value exceeds the limit, is the child ineligible("I") or is the excess applied ("A") to the threshold allowable amount for other assets? *(Enter I or A)*	N/A	N/A		

*Make a separate column for each "other" program identified in Section 2.1.1. To add a column to a table, right click on the mouse, select "insert" and choose "column".

3.1.1.8 Have any of the eligibility rules changed since September 30, 1999? ___ Yes __X__ No

3.1.2 How often is eligibility redetermined?

Table 3.1.2			
Redetermination	Medicaid CHIP Expansion Program	State-designed CHIP Program	Other CHIP Program* _____
Monthly			
Every six months			
Every twelve months	**x**		
Other (specify)_____			

*Make a separate column for each "other" program identified in Section 2.1.1. To add a column to a table, right click on the mouse, select "insert" and choose "column".

3.1.3 Is eligibility guaranteed for a specified period of time regardless of income changes? (Section 2108(b)(1)(B)(v))

___ Yes ° Which program(s)? _____

For how long?_____

_x_ No

3.1.4 Does the CHIP program provide retroactive eligibility?

_x_ Yes ° Which program(s)? **Medicaid expansion**

How many months look-back? **3 months**

___ No

3.1.5 Does the CHIP program have presumptive eligibility?

___ Yes ° Which program(s)? _____

Which populations?_____

Who determines?_____

_x_ No

3.1.6 Do your Medicaid program and CHIP program have a joint application?

_x_ Yes ° Is the joint application used to determine eligibility for other State programs? If yes, specify. **Medical Assistance, General Assistance Medical Care, MinnesotaCare, and the Senior Drug Program**.

___ No

3.1.7 Evaluate the strengths and weaknesses of your *eligibility determination* process in increasing creditable health coverage among targeted low-income children

Until recently, we had a combined application that was 24 pages long. That was partly because it was formatted for easy readability, and partly because it contained space for all of the questions necessary to determine eligibility for one of the four programs listed in paragraph 3.1.6. In March of this year, we introduced a four-page application, in combination with a delayed verification process. Workers enroll those who appear to be eligible from the information on the application, and the applicant then has 30 days to submit the necessary verification of income and/or assets.

The new application takes about 30 minutes to complete, as opposed to the 70 minutes for the old form. It is easier to understand, well-organized, and color-coded. It is the result of more than a year of collaboration with assistance and representation from county workers, advocates, providers, and focus groups of applicants and enrollees. It is available now on our web site to print down, and we are planning for a time when people will be able to apply on-line.

Another strength is the mail-in application. For several years now, applicants have been able to apply for the four health care programs by mailing a completed form directly to the state or county, instead of having to schedule an appointment with a county worker. People can still apply through the county, but there are obvious advantages for those who do not want to go their county office to apply; whose work schedules make an in-person application very difficult; or who have difficulty obtaining transportation, among other reasons.

3.1.8 Evaluate the strengths and weaknesses of your *eligibility redetermination* process in increasing creditable health coverage among targeted low-income children. How does the redetermination process differ from the initial eligibility determination process?

Along with the new application, we recently introduced a simplified, one-page redetermination form. The renewal process differs from initial eligibility in that, other than the applicant's name, address and income, it only asks for changes that have occurred since the previous application (i.e., pregnancy, marriage, changes in assets).

A weakness of the eligibility and redetermination process is the way the eligibility system handles health care programs. Health care eligibility was built onto the eligibility system for TANF and other state financial asssistance programs, and is not fully automated. It allows for more caseworker discretion, and error. For example, when a family's TANF case is terminated, the caseworker is required to redetermine eligibility for health care under all potential bases of eligibility, and that occurs in the vast majority of cases. However, if a TANF participant fails to return a review form, the system automatically closes TANF and MA. We are implementing a "workaround" to address this situation. We are currently evaluating bids to develop a blueprint for a fully automated eligibility system for Minnesota's health care programs.

Another weakness in the MA program, is the requirement that people report income quarterly during the period of extended medical assistance. Though we use a simple, mail-in report form, people lose coverage during the extended period because they fail to turn in the income report form, or they have moved and have

not reported the move, even though they remain eligible for the program. We are currently negotiating a waiver of this requirement, which is included in a package of changes to the MinnesotaCare §1115 waiver.

3.2 What benefits do children receive and how is the delivery system structured? Section 2108(b)(1)(B)(vi))

3.2.1 Benefits

Please complete Table 3.2.1 for each of your CHIP programs, showing which benefits are covered, the extent of cost-sharing (if any), and benefit limits (if any).

NOTE: To duplicate a table: put cursor on desired table go to Edit menu and chose "select" "table." Once the table is highlighted, copy it by selecting "copy" in the Edit menu and then "paste" it under the first table.

Table 3.2.1 CHIP Program Type Medicaid Expansion

Benefit	Is Service Covered? (**T** = yes)	Cost-Sharing (Specify)	Benefit Limits (Specify)
Inpatient hospital services	***/***		**The benefit set for the S-CHIP expansion group is identical to the MA benefit set for children, which is listed in Attachments 3.19A and B of the Minnesota Medicaid State Plan. That benefit set includes all mandatory and optional services that can be covered under Title XIX (with the exception of nursing in religious nonmedical institutions). There are no major benefit limits such as an annual cap on inpatient days or physician visits. However, Attachments 3.19A and B itemize many utilization control mechanisms such as prior authorization thresholds, define settings in which services must be provided, etc. Those mechanisms are too numerous to include here.**
Emergency hospital services	***/***		
Outpatient hospital services	***/***		
Physician services	***/***		
Clinic services	***/***		

Table 3.2.1 CHIP Program Type Medicaid Expansion			
Benefit	Is Service Covered? (**T** = yes)	Cost-Sharing (Specify)	Benefit Limits (Specify)
Prescription drugs	**/**		
Over-the-counter medications	**/**		
Outpatient laboratory and radiology services	**/**		
Prenatal care	**/**		
Family planning services	**/**		
Inpatient mental health services	**/**		
Outpatient mental health services	**/**		
Inpatient substance abuse treatment services	**/**		
Residential substance abuse treatment services	**/**		
Outpatient substance abuse treatment services	**/**		
Durable medical equipment	**/**		
Disposable medical supplies	**/**		
Preventive dental services	**/**		
Restorative dental services	**/**		

Table 3.2.1 CHIP Program Type Medicaid Expansion			
Benefit	Is Service Covered? (**T** = yes)	Cost-Sharing (Specify)	Benefit Limits (Specify)
Hearing screening	**/**		
Hearing aids	**/**		
Vision screening	**/**		
Corrective lenses (including eyeglasses)	**/**		
Developmental assessment	**/**		
Immunizations	**/**		
Well-baby visits	**/**		
Well-child visits	**/**		
Physical therapy	**/**		
Speech therapy	**/**		
Occupational therapy	**/**		
Physical rehabilitation services	**/**		
Podiatric services	**/**		
Chiropractic services	**/**		
Medical transportation	**/**		
Home health services	**/**		

Table 3.2.1 CHIP Program Type Medicaid Expansion			
Benefit	Is Service Covered? (**T** = yes)	Cost-Sharing (Specify)	Benefit Limits (Specify)
Nursing facility	**/**		
ICF/MR	**/**		
Hospice care	**/**		
Private duty nursing	**/**		
Personal care services	**/**		
Habilitative services	**/**		
Case management/Care coordination	**/**		
Non-emergency transportation	**/**		
Interpreter services	**/**		**Interpreters for people with hearing impairments are covered as administrative expenditures. Certain providers are required by the terms of state licensure to have foreign language interpretation services available.**
Other (Specify)_____			
Other (Specify)_____			
Other (Specify)_____			

NOTE: To duplicate a table: put cursor on desired table go to Edit menu and chose "select" "table." Once the table is highlighted, copy it by selecting "copy" in the Edit menu and then "paste" it under the first table.

3.2.2 Scope and Range of Health Benefits (Section 2108(b)(1)(B)(ii))

Please comment on the scope and range of health coverage provided, including the types of benefits provided and cost-sharing requirements. Please highlight the level of preventive services offered and services available to children with special health care needs. Also, describe any enabling services offered to CHIP enrollees. (Enabling services include non-emergency transportation, interpretation, individual needs assessment, home visits, community outreach, translation of written materials, and other services designed to facilitate access to care.)

There are no cost-sharing requirements in the MA program. There are no limits on preventive services available to children, including those with special needs. MA also covers non-emergency transportation to medical appointments. See section 3.4.4 regarding translation of written materials to promote access to care.

As stated earlier, Minnesota covers all mandatory and optional services available under Title XIX (with the exception of nursing in religious nonmedical institutions). Minnesota also has four home and community-based waiver programs that are available to special needs children, including children with mental retardation or related conditions, traumatic brain injury, and other disabled children at risk of institutional care.

3.2.3 Delivery System

Identify in Table 3.2.3 the methods of delivery of the child health assistance using Title XXI funds to targeted low-income children. Check all that apply.

Table 3.2.3

Type of delivery system	Medicaid CHIP Expansion Program	State-designed CHIP Program	Other CHIP Program* _____
A. Comprehensive risk managed care organizations (MCOs)			
Statewide?	___ Yes **_x_** No	___ Yes ___ No	___ Yes ___ No
Mandatory enrollment?	**_x_** Yes ___ No	___ Yes ___ No	___ Yes ___ No
Number of MCOs	**8**		
B. Primary care case management (PCCM) program			
C. Non-comprehensive risk contractors for selected services such as mental health, dental, or vision (specify services that are carved out to managed care, if applicable)			
D. Indemnity/fee-for-service (specify services that are carved out to FFS, if applicable)	**IEP services, targeted mental health case management, targeted child welfare case management, home and community-based waiver services, nursing facility and ICF/MR services are all carved out to fee-for-service.** **Also, some counties are not included in the managed care delivery system. In those counties, MA enrollees receive all services on a fee-for-service basis.**		
E. Other (specify)_____			

Table 3.2.3			
F. Other (specify)_____			
G. Other (specify)_____			

*Make a separate column for each "other" program identified in Section 2.1.1. To add a column to a table, right click on the mouse, select "insert" and choose "column".

3.3 How much does CHIP cost families?

3.3.1 Is cost sharing imposed on any of the families covered under the plan? (Cost sharing includes premiums, enrollment fees, deductibles, coinsurance/ copayments, or other out-of-pocket expenses paid by the family.)

_x_ No, skip to section 3.4

___ Yes, check all that apply in Table 3.3.1

Table 3.3.1			
Type of cost-sharing	Medicaid CHIP Expansion Program	State-designed CHIP Program	Other CHIP Program* _____
Premiums			
Enrollment fee			
Deductibles			
Coinsurance/copayments**			
Other (specify) _____			

o a table, right click on the mouse, select "insert" and choose "column".

**See Table 3.2.1 for detailed information.

3.3.2 **If premiums are charged:** What is the level of premiums and how do they vary by program, income, family size, or other criteria? (Describe criteria and attach schedule.) How often are premiums collected? What do you do if families fail to pay the premium? Is there a waiting period (lock-out) before a family can re-enroll? Do you have any innovative approaches to premium collection?

3.3.3 **If premiums are charged:** Who may pay for the premium? Check all that apply. (Section 2108(b)(1)(B)(iii))

___ Employer

___ Family
___ Absent parent
___ Private donations/sponsorship
___ Other (specify) _____

3.3.4 **If enrollment fee is charged:** What is the amount of the enrollment fee and how does it vary by program, income, family size, or other criteria?

3.3.5 **If deductibles are charged:** What is the amount of deductibles (specify, including variations by program, health plan, type of service, and other criteria)?

3.3.6 How are families notified of their cost-sharing requirements under CHIP, including the 5 percent cap?

3.3.7 How is your CHIP program monitoring that annual aggregate cost-sharing does not exceed 5 percent of family income? Check all that apply below and include a narrative providing further details on the approach.

___ Shoebox method (families save records documenting cumulative level of cost sharing)
___ Health plan administration (health plans track cumulative level of cost sharing)
___ Audit and reconciliation (State performs audit of utilization and cost sharing)
___ Other (specify)_____

3.3.8 What percent of families hit the 5 percent cap since your CHIP program was implemented? (If more than one CHIP program with cost sharing, specify for each program.)

3.3.9 Has your State undertaken any assessment of the effects of premiums on participation or the effects of cost sharing on utilization, and if so, what have you found?

3.4 How do you reach and inform potential enrollees?

3.4.1 What client education and outreach approaches does your CHIP program use?

Please complete Table 3.4.1. Identify all of the client education and outreach approaches used by your CHIP program(s). Specify which approaches are used (**T**=yes) and then rate the effectiveness of each approach on a scale of 1 to 5, where 1=least effective and 5=most effective**.**

Table 3.4.1						
Approach	Medicaid CHIP Expansion		State-Designed CHIP Program		Other CHIP Program* _____	
	T = Yes	Rating (1-5)	**T** = Yes	Rating (1-5)	**T** = Yes	Rating (1-5)
Billboards						
Brochures/flyers	/	**3**				
Direct mail by State/enrollment broker/administrative contractor	/	**2**				
Education sessions	/	**3**				
Home visits by State/enrollment broker/administrative contractor	/	**5**				
Hotline	/	**4 -- person/answer 1--voice mail**				
Incentives for education/outreach staff						
Incentives for enrollees	/	**3**				
Incentives for insurance agents						
Non-traditional hours for application intake	/	**5**				
Prime-time TV advertisements						
Public access cable TV	/	**3 elderly**				

Table 3.4.1						
Public transportation ads						
Radio/newspaper/TV advertisement and PSAs	/	**4**				
Signs/posters	/	**2**				
State/broker initiated phone calls	/	**3**				
Other (specify) Payroll stuffers	/	**3**				
Other (specify) Utility bills and energy assistance mailings	/	**2**				

*Make a separate column for each "other" program identified in section 2.1.1. To add a column to a table, right click on the mouse, select "insert" and choose "column".

3.4.2 Where does your CHIP program conduct client education and outreach?

Please complete Table 3.4.2. Identify all the settings used by your CHIP program(s) for client education and outreach. Specify which settings are used (**T**=yes) and then rate the effectiveness of each setting on a scale of 1 to 5, where 1=least effective and 5=most effective.

Table 3.4.2

Setting	Medicaid CHIP Expansion		State-Designed CHIP Program		Other CHIP Program* _____	
	T = Yes	Rating (1-5)	**T** = Yes	Rating (1-5)	**T** = Yes	Rating (1-5)
Battered women shelters						
Community sponsored events	/	**3**				
Beneficiary's home	/	**5**				
Day care centers						
Faith communities	/	**4**				
Fast food restaurants						
Grocery stores	/	**3**				
Homeless shelters						
Job training centers	/	**3**				
Laundromats	/	**2**				
Libraries	/	**Just started**				
Local/community health centers	/	**5**				
Point of service/provider locations	/	**5**				
Public meetings/health fairs	/	**3**				
Public housing						

Table 3.4.2						
Refugee resettlement programs	/	**4**				
Schools/adult education sites	/	**4**				
Senior centers						
Social service agency	/	**5**				
Workplace	/	**4**				
Other (specify) WIC and public health functions	/	**4**				
Other (specify) HeadStart	/	**3**				

*Make a separate column for each "other" program identified in section 2.1.1. To add a column to a table, right click on the mouse, select "insert" and choose "column".

3.4.3 Describe methods and indicators used to assess outreach effectiveness, such as the number of children enrolled relative to the particular target population. Please be as specific and detailed as possible. Attach reports or other documentation where available.

We conducted some research related to the effectiveness of outreach in the MinnesotaCare Program, but none directed at the S-CHIP, Medicaid Expansion group.

3.4.4 What communication approaches are being used to reach families of varying ethnic backgrounds?

- **The Health Care application is being translated in seven languages.**
- **Application support materials (fact sheet, brochures, etc.) are being translated into seven languages.**
- **Radio PSAs in Spanish and Hmong languages**
- **TV/Cable access for Spanish and Hmong languages**
- **Translated PSAs and articles in culturally specific "shopper" type newspapers.**
- **Posters in different languages**
- **Outreach contracts with three agencies whose primary objective is to serve clients with limited English proficiency, and nine additional agencies who have bilingual staff to serve people with limited English proficiency. These agencies provide education and one-to-one enrollment assistance for clients who speak Spanish, Hmong, Vietnamese and Somalian.**

3.4.5 Have any of the outreach activities been more successful in reaching certain populations? Which methods best reached which populations? How have you measured their effectiveness? Please present quantitative findings where available.

- **Radio has been more effective for the southeast Asian audience, their reliance on spoken language, and strong affiliation with Asian radio programming makes radio a good strategy with this population.**

- **One outreach grantee that serves southeast Asian people reported 60 percent of their referrals for health care information coming from radio advertising.**

3.5 What other health programs are available to CHIP eligibles and how do you coordinate with them? (Section 2108(b)(1)(D))

Describe procedures to coordinate among CHIP programs, other health care programs, and non-health care programs. Table 3.5 identifies possible areas of coordination between CHIP and other programs (such as Medicaid, MCH, WIC, School Lunch). Check all areas in which coordination takes place and specify the nature of coordination in narrative text, either on the table or in an attachment.

Because of the importance of health care coverage for the populations they serve, both the Title V and WIC programs are aggressive in their attempts to identify children who are uninsured or underinsured; and to assist families in determining what public/private program best meets their needs, assist the family through the application process, and assist families in obtaining access to services once eligibility has been established. This is accomplished by:

-Requiring Maternal and Child Health grantees to discuss health care coverage with all clients

-Use of an toll-free telephone hotline for children with special health care needs to assist parents in identifying appropriate public or private sources of coverage

-Use of the same application by MinnesotaCare and Minnesota Children with Special Health Care Needs Program.

-Making available at Title V/WIC clinic sites Minnesota Health Care Program applications and a screening tool for pregnant women and children under age two.

-Discussing health care coverage issues with families at the 300 WIC clinics throughout the State.

-Providing information on available public resources to general public through fliers and brochures.

-Providing formal training for professionals about available public resources via Title V- sponsored workshops or ad hoc meetings.

In addition, grantees of Maternal and Child Health Special Project funds have specific outreach plans for high risk pregnant women, and strategies to assure complete prenatal care including referral for Minnesota Health Care Program eligibility determinations.

Table 3.5

Type of coordination	Medicaid*	Maternal and child health	Other (specify) **MinnesotaCare**	Other (specify) **WIC**
Administration		**yes**	**yes**	
Outreach		**yes**	**yes**	**yes**
Eligibility determination		**yes**	**yes**	
Service delivery		**yes**	**yes**	

Procurement			**yes**	
Contracting			**yes**	
Data collection			**yes**	
Quality assurance			**yes**	
Other (specify) _____			**yes**	
Other (specify) _____			**yes**	

*Note: This column is not applicable for States with a Medicaid CHIP expansion program only.

3.6 How do you avoid crowd-out of private insurance?

3.6.1 Describe anti-crowd-out policies implemented by your CHIP program. If there are differences across programs, please describe for each program separately. Check all that apply and describe.

Eligibility determination process:

___ Waiting period without health insurance (specify) _____
__ Information on current or previous health insurance gathered on application (specify) _____
_____
___ Information verified with employer (specify) _____
___ Records match (specify) _____
___ Other (specify) _____
___ Other (specify) _____

___ Benefit package design:

___ Benefit limits (specify) _____
___ Cost-sharing (specify) _____
___ Other (specify) _____
___ Other (specify) _____

___ Other policies intended to avoid crowd out (e.g., insurance reform):

___ Other (specify) _____
___ Other (specify) _____

3.6.2 How do you monitor crowd-out? What have you found? Please attach any available reports or other documentation.

We do not monitor crowd-out related to this narrow S-CHIP eligibility category. There are very few uninsured children under age two in families with income above 275% and at or below 280% of federal poverty. Very few of those would drop existing coverage, for various reasons. This is confirmed by the fact that only 19 children were enrolled in this category throughout FFY 1999. There have been at least two studies that looked at crowd-out, or private market erosion, in Minnesota since the insurance reforms and implementation of the MinnesotaCare Program in the early 1990s, and no measurable crowd-out has been identified.

SECTION 4. PROGRAM ASSESSMENT

This section is designed to assess the effectiveness of your CHIP program(s), including enrollment, disenrollment, expenditures, access to care, and quality of care.

4.1 Who enrolled in your CHIP program?

4.1.1 What are the characteristics of children enrolled in your CHIP program? (Section 2108(b)(1)(B)(i))

Please complete Table 4.1.1 for each of your CHIP programs, based on data from your HCFA quarterly enrollment reports. Summarize the number of children enrolled and their characteristics. Also, discuss average length of enrollment (number of months) and how this varies by characteristics of children and families, as well as across programs.

States are also encouraged to provide additional tables on enrollment by other characteristics, including gender, race, ethnicity, parental employment status, parental marital status, urban/rural location, and immigrant status. Use the same format as Table 4.1.1, if possible.

NOTE: To duplicate a table: put cursor on desired table go to Edit menu and chose "select" "table." Once the table is highlighted, copy it by selecting "copy" in the Edit menu and then "paste" it under the first table.

Table 4.1.1 CHIP Program Type Medicaid Expansion

Characteristics	Number of children ever enrolled		Average number of months of enrollment		Number of disenrollees	
	FFY 1998	FFY 1999	FFY 1998	FFY 1999	FFY 1998	FFY 1999
All Children		**19**		**4.6**		**17**
Age						
Under 1		**9**		**4.4**		**8**
1-5 **(1-2)**		**10**		**4.7**		**9**
6-12						
13-18						
Countable Income Level*						

Table 4.1.1 CHIP Program Type Medicaid Expansion						
Characteristics	Number of children ever enrolled		Average number of months of enrollment		Number of disenrollees	
	FFY 1998	FFY 1999	FFY 1998	FFY 1999	FFY 1998	FFY 1999
At or below 150% FPL						
Above 150% FPL		19		4.6		17
Age and Income						
Under 1						
At or below 150% FPL						
Above 150% FPL		9		4.0		8
1-5 **(1-2)**						
At or below 150% FPL						
Above 150% FPL		10		5.4		9
6-12						
At or below 150% FPL						
Above 150% FPL						
13-18						
At or below 150% FPL						
Above 150% FPL						

Table 4.1.1 CHIP Program Type Medicaid Expansion						
Characteristics	Number of children ever enrolled		Average number of months of enrollment		Number of disenrollees	
	FFY 1998	FFY 1999	FFY 1998	FFY 1999	FFY 1998	FFY 1999
Type of plan						
Fee-for-service		11		4.5		9
Managed care		8		4.8		8
PCCM						

*Countable Income Level is as defined by the states for those that impose premiums at defined levels other than 150% FPL. See the HCFA Quarterly Report instructions for further details.

SOURCE: HCFA Quarterly Enrollment Reports, Forms HCFA-21E, HCFA-64.21E, HCFA-64EC, HCFA Statistical Information Management System, October 1998

4.1.2 How many CHIP enrollees had access to or coverage by health insurance prior to enrollment in CHIP? Please indicate the source of these data (e.g., application form, survey). (Section 2108(b)(1)(B)(i)) **DK**

4.1.3 What is the effectiveness of other public and private programs in the State in increasing the availability of affordable quality individual and family health insurance for children? (Section 2108(b)(1)(C)) **See Attachment 1, "Characteristics and Trends Among Minnesota's Uninsured Population," by the Minnesota Department of Health, Health Economics Program.**

4.2 Who disenrolled from your CHIP program and why?

4.2.1 How many children disenrolled from your CHIP program(s)? Please discuss disenrollment rates presented in Table 4.1.1. Was disenrollment higher or lower than expected? How do CHIP disenrollment rates compare to traditional Medicaid disenrollment rates?

17 children disenrolled in FFY 1999. Because of the low numbers, no comparisons can be drawn to Medicaid disenrollment.

4.2.2 How many children did not re-enroll at renewal? How many of the children who did not re-enroll got other coverage when they left CHIP? **DK**

4.2.3 What were the reasons for discontinuation of coverage under CHIP? (Please specify data source, methodologies, and reporting period.)

Table 4.2.3

Reason for discontinuation of coverage	Medicaid CHIP Expansion Program		State-designed CHIP Program		Other CHIP Program* _____	
	Number of disenrollees	Percent of total	Number of disenrollees	Percent of total	Number of disenrollees	Percent of total
Total	**17****	**89.5**				
Access to commercial insurance						
Eligible for Medicaid						
Income too high	**4**	**21.05**				
Aged out of program	**4**	**21.05**				
Moved/died	**1**	**5.26**				
Nonpayment of premium						
Incomplete documentation	**5**	**26.32**				
Did not reply/unable to contact						
Other (specify) Income dropped below %275FPG	**4**	**21.05**				
Other (specify) TEFRA eligibility	**1**	**5.26**				
Other (specify) Requested closure	**1**	**5.26**				

*Make a separate column for each "other" program identified in section 2.1.1. To add a column to a table, right click on the mouse, select "insert" and choose "column".

****Some cases had more than one reason for closure.**

4.2.4 What steps is your State taking to ensure that children who disenroll, but are still eligible, re-enroll?

Prior to MA termination, workers receive a system message to redetermine MA eligibility under another basis. If the enrollee remains ineligible for MA, the worker determines eligibility for MinnesotaCare, or transfers the file to MinnesotaCare Enrollment and Operations for an eligibility determination.

In February 2000, the State introduced a shortened health care application and renewal form. These new forms simplify the application and renewal process, ensuring that more people will follow through with application and renewal.

Beginning 7/1/00, individuals who leave MA are eligible for MinnesotaCare retroactively. Enrollees will not have a gap in coverage as they transition from one health care program to another.

In the near future, TANF applicants will receive a brochure explaining how MA works with TANF, including a section on health care options when MA ends.

In the near future, MA enrollees receiving extended medical will receive a brochure explaining public and private health insurance options.

4.3 How much did you spend on your CHIP program?

4.3.1 What were the total expenditures for your CHIP program in federal fiscal year (FFY) 1998 and 1999?

FFY 1998 _____

FFY 1999 **$23,509.29**

Please complete Table 4.3.1 for each of your CHIP programs and summarize expenditures by category (total computable expenditures and federal share). What proportion was spent on purchasing private health insurance premiums versus purchasing direct services?

Table 4.3.1 CHIP Program Type Medicaid Expansion

Type of expenditure	Total computable share		Total federal share	
	FFY 1998	FFY 1999	FFY 1998	FFY 1999
Total expenditures		**$23,509.29**		**$15,527.89**
Premiums for private health insurance (net of cost-sharing offsets)*		**$14,026.92**		**$ 9,264.78**

Table 4.3.1 CHIP Program Type Medicaid Expansion				
Type of expenditure	Total computable share		Total federal share	
	FFY 1998	FFY 1999	FFY 1998	FFY 1999
Fee-for-service expenditures (subtotal)		**$ 9,482.37**		**$ 6,263.11**
Inpatient hospital services		**$ 1,407.51**		**$ 929.66**
Inpatient mental health facility services		**0**		**0**
Nursing care services		**0**		**0**
Physician and surgical services		**$ 395.86**		**$ 261.47**
Outpatient hospital services		**$ 33.00**		**$ 21.80**
Outpatient mental health facility services		**Included in "other"**		**Included in "other"**
Prescribed drugs		**$ 576.23**		**$ 380.60**
Dental services		**0**		**0**
Vision services		**Included in "other"**		**Included in "other"**
Other practitioners' services		**$ 196.26**		**$ 129.63**
Clinic services		**0**		**0**
Therapy and rehabilitation services		**Included in "other"**		**Included in "other"**
Laboratory and radiological services		**0**		**0**
Durable and disposable medical equipment		**Included in "other"**		**Included in "other"**
Family planning		**0**		**0**
Abortions				

Table 4.3.1 CHIP Program Type Medicaid Expansion				
Type of expenditure	Total computable share		Total federal share	
	FFY 1998	FFY 1999	FFY 1998	FFY 1999
Screening services		**$ 142.00**		**$ 93.79**
Home health		**$ 4,571.77**		**$ 3,138.54**
Home and community-based services		**0**		**0**
Hospice		**0**		**0**
Medical transportation		**Included in "other"**		**Included in "other"**
Case management		**$ 1,735.00**		**$ 1,145.97**
Other services		**$ 244.74**		**$ 161.65**

4.3.2 What were the total expenditures that applied to the 10 percent limit? Please complete Table 4.3.2 and summarize expenditures by category.

What types of activities were funded under the 10 percent cap?__**None**_____

What role did the 10 percent cap have in program design? _**None**_____

Table 4.3.2

Type of expenditure	Medicaid Chip Expansion Program		State-designed CHIP Program		Other CHIP Program* _____	
	FY 1998	FY 1999	FY 1998	FY 1999	FY 1998	FY 1999
Total computable share		**0**				
Outreach		**0**				
Administration		**0**				
Other		**0**				
Federal share		**0**				
Outreach		**0**				
Administration		**0**				
Other _____		**0**				

*Make a separate column for each "other" program identified in section 2.1.1. To add a column to a table, right click on the mouse, select "insert" and choose "column".

4.3.3 What were the non-Federal sources of funds spent on your CHIP program (Section 2108(b)(1)(B)(vii))

_**x**_ State appropriations
___ County/local funds
___ Employer contributions
___ Foundation grants
___ Private donations (such as United Way, sponsorship)
___ Other (specify) _____

4.4 How are you assuring CHIP enrollees have access to care?

4.4.1 What processes are being used to monitor and evaluate access to care received by CHIP enrollees?

Please specify each delivery system used (from question 3.2.3) if approaches vary by the delivery system withing each program. For example, if an approach is used in managed care, specify 'MCO.' If an approach is used in fee-for-service, specify 'FFS.' If an approach is used in a Primary Care Case Management program, specify 'PCCM.'

Table 4.4.1

Approaches to monitoring access	**Medicaid CHIP Expansion Program**	State-designed CHIP Program	Other CHIP Program* _____
Appointment audits			
PCP/enrollee ratios	**MCO**		
Time/distance standards	**MCO**		
Urgent/routine care access standards	**MCO**		
Network capacity reviews (rural providers, safety net providers, specialty mix)	**MCO**		
Complaint/grievance/ disenrollment reviews	**MCO (both), FFS (complaints & grievances only)**		
Case file reviews	**MCO**		
Beneficiary surveys	**MCO**		
Utilization analysis (emergency room use, preventive care use)	**MCO, FFS**		
Other (specify) _____			
Other (specify) _____			
Other (specify) _____			

*Make a separate column for each "other" program identified in section 2.1.1. To add a column to a table, right click on the mouse, select "insert" and choose "column".

4.4.2 What kind of managed care utilization data are you collecting for each of your CHIP programs? If your State has no contracts with health plans, skip to section 4.4.3.

Table 4.4.2

Type of utilization data	Medicaid CHIP Expansion Program	State-designed CHIP Program	Other CHIP Program* _____
Requiring submission of raw encounter data by health plans	_x_ Yes ___ No	___ Yes ___ No	___ Yes ___ No
Requiring submission of aggregate HEDIS data by health plans	_x_ Yes ___ No	___ Yes ___ No	___ Yes ___ No
Other (specify)_____	___ Yes ___ No	___ Yes ___ No	___ Yes ___ No

*Make a separate column for each "other" program identified in section 2.1.1. To add a column to a table, right click on the mouse, select "insert" and choose "column".

4.4.3 What information (if any) is currently available on access to care by CHIP enrollees in your State? Please summarize the results.

The Minnesota Health Data Institute just completed the "Medicaid and MinnesotaCare Health Quality Survey Results, 1999," which was commissioned by the Department of Human Services. It will be available on the Minnesota DHS website in the very near future.
http://www.dhs.state.mn.us/hlthcare/PMQI/default.htm

DHS also submitted a report to the 1999 Minnesota Legislature regarding access to dental care for Medicaid enrollees. It is available on the DHS web site.
http://www.dhs.state.mn.us/hlthcare/reportsmanuals/dental.htm

4.4.4 What plans does your CHIP program have for future monitoring/evaluation of access to care by CHIP enrollees? When will data be available?

An access survey is conducted every year–in one year the State conducts the survey, and in the alternate years the health plans are required to conduct the survey.

HEDIS data for CY 1999 will be available in July, 2000. Included in the data to be analyzed:

Well-child visits in the first 15 months of life
Admissions and average length of stay–maternity care
Cesarean section rate
Childhood immunizations
Prenatal care in the first trimester
Low birth-weight
Check-ups after delivery

4.5 How are you measuring the quality of care received by CHIP enrollees?

4.5.1 What processes are you using to monitor and evaluate quality of care received by CHIP enrollees, particularly with respect to well-baby care, well-child care, and immunizations? Please specify the approaches used to monitor quality within each delivery system (from question 3.2.3). For example, if an approach is used in managed care, specify 'MCO.' If an approach is used in fee-for-service, specify 'FFS.' If an approach is used in primary care case management, specify 'PCCM.'

Table 4.5.1

Approaches to monitoring quality	Medicaid CHIP Expansion Program	State-designed CHIP Program	Other CHIP Program
Focused studies (specify)	**MCO**		
Client satisfaction surveys	**MCO**		
Complaint/grievance/ disenrollment reviews	**MCO (both), FFS (complaints & grievances only)**		
Sentinel event reviews			
Plan site visits	**MCO**		
Case file reviews	**MCO, FFS**		
Independent peer review	**MCO, FFS**		
HEDIS performance measurement	**MCO**		
Other performance measurement (specify)			
Other (specify) **Linking prenatal care information and birth records/outcomes**	**MCO, FFS**		
Other (specify)			
Other (specify)			

*Make a separate column for each "other" program identified in section 2.1.1. To add a column to a table, right click on the mouse, select "insert" and choose "column".

4.5.2 What information (if any) is currently available on quality of care received by CHIP enrollees in your State? Please summarize the results.

A report entitled Minnesota Prepaid Medical Assistance Program (PMAP) Performance Measures, dated June, 1999 is also available on the DHS website. It is based on data collected prior to implementation of the S-CHIP expansion group, but future reports will include these children as part of the Medicaid population. http://www.dhs.state.mn.us/hlthcare/PMQI/PMAP_TB.htm

The results of the annual external quality review study will be available in the summer of 2000. This includes an extensive medical record review that will compare EPSDT information to the actual medical records.

4.5.3 What plans does your CHIP program have for future monitoring/evaluation of quality of care received by CHIP enrollees? When will data be available?

DHS is currently collaborating with the Minnesota Department of Health on a research project to produce baseline data on demographics, risk factors, and birth outcomes for the Medicaid population by matching birth certificate data to Medicaid deliveries. The combined database will allow DHS to study birth outcomes in the Medicaid population and track disparities between the Medicaid and non-Medicaid populations. The information resulting from this research will assist DHS and policy makers in tailoring programs and services for pregnant women, new parents and their children, and educate providers about special risks faced by Medicaid enrollees.

The Minnesota Pregnancy Assessment Form is a uniform tool used by Medicaid providers to determine a pregnant woman's risk for preterm labor, a low birth-weight baby, or a poor birth outcome. DHS currently requires providers of routine prenatal care services to perform a risk assessment for all pregnant women at the first prenatal visit thereby facilitating early intervention, education, and enhanced services. The assessment form will also be used as a research tool to study the relationship between pregnancy risk factors and birth outcome, analyze the effectiveness of early interventions and specialized services, and evaluate enhanced services. This information from this research will allow DHS and policy makers to tailor services to meet the need of pregnant women who are at risk, and inform providers of the impact of certain risk factor or combination of risk factor can have on birth outcomes for this population.

Many of the approaches to monitoring quality that are reported in table 4.5.1 are conducted on an ongoing basis.

4.6 Please attach any reports or other documents addressing access, quality, utilization, costs, satisfaction, or other aspects of your CHIP program's performance. Please list attachments here.

Minnesota Prepaid Medical Assistance Program (PMAP) Performance Measures, June 1999.

SECTION 5. REFLECTIONS

This section is designed to identify lessons learned by the State during the early implementation of its CHIP program as well as to discuss ways in which the State plans to improve its CHIP program in the future. The State evaluation should conclude with recommendations of how the Title XXI program could be improved.

5.1 What worked and what didn't work when designing and implementing your CHIP program? What lessons have you learned? What are your "best practices"? Where possible, describe what evaluation efforts have been completed, are underway, or planned to analyze what worked and what didn't work. Be as specific and detailed as possible. (Answer all that apply. Enter 'NA' for not applicable.)

5.1.1 Eligibility Determination/Redetermination and Enrollment

Because this was such a small eligibility expansion that we estimated would cover less than 20 children, and because of other systems priorities at the time, we elected not to create a separate "major program" or "eligibility type" in the system for this category. That decision has created problems and delays in counting these eligibles for purposes of the federal claim and the statistical reports.

5.1.2 Outreach

5.1.3 Benefit Structure

5.1.4 Cost-Sharing (such as premiums, copayments, compliance with 5% cap)

5.1.5 Delivery System

5.1.6 Coordination with Other Programs (especially private insurance and crowd-out)

5.1.7 Evaluation and Monitoring (including data reporting)

5.1.8 Other (specify)

5.2 What plans does your State have for "improving the availability of health insurance and health care for children"? (Section 2108(b)(1)(F))

5.3 What recommendations does your State have for improving the Title XXI program? (Section 2108(b)(1)(G)).

Minnesota just submitted a new §1115 waiver request to enable the State to make coverage available and to conduct special health initiatives for the 48,000 children who remain uninsured in this state, most of whom are in low-income families. HCFA should consider that waiver in light of those children who are otherwise disadvantaged by Minnesota's earlier initiatives an commitment to insuring all children.

It is important to note that states cannot effectively cover all children as long as the citizenship barriers are in place in both the Medicaid and S-CHIP Programs.

We also note that, despite Congress' intent to give states the flexibility to use this funding to subsidize families' costs in purchasing coverage through their employers, HCFA proposed rules, mainly due to concerns about "crowd-out," have eliminated most of the flexibility that was intended by Congress.

Also, HCFA and Congress should consider giving states the option of eliminating the quarterly income reporting requirements in the law governing extended medical care. We have found that many people lose extended medical because they fail to return those forms even though they remain eligible for Medicaid.

Characteristics and Trends Among Minnesota's Uninsured Population[1]

Introduction

The Health Economics Program of the Minnesota Department of Health monitors Minnesota's health care market and develops estimates of the distribution of insurance coverage among Minnesotans. Studies describing the characteristics of the uninsured and trends among the uninsured population are important to policymakers as they continue to search for ways to increase access to health insurance for all people in the state. This issue paper examines various estimates of the rate of uninsurance in Minnesota, provides information on Minnesota's rate of uninsurance over time, describes changes in the demographic composition of the uninsured over the last decade, provides information on the characteristics of uninsured children, people of color, and low-income individuals in the state, and analyzes the availability of private and public health insurance for uninsured Minnesotans.

Estimates of the Number of Uninsured Minnesotans

Various surveys measuring health insurance coverage are conducted in Minnesota on a yearly and periodic basis. Results from these surveys continue to show that Minnesota has one of the lowest rates of uninsurance in the country.[1] Although these surveys agree on the low rate of uninsurance in Minnesota compared to other states, they do not agree on the number of uninsured Minnesotans. Current estimates of the uninsured in Minnesota range from 5.3% or 253,000 people to 9.6% or 458,000 people.

It is difficult to compare the estimates of the uninsured in Minnesota because each survey that measures the rate of uninsurance uses a different methodology. There are two surveys conducted on an annual basis that measure the rate of uninsurance at the national and state level. The Current Population Survey (CPS) provides a ***whole-year estimate*** of the uninsured, which means that the survey asks questions about insurance coverage during the entire year.[2] In addition, the CPS uses a ***residual approach*** to determine rates of uninsurance. In other words, the CPS does not directly ask about uninsurance, but assumes that a person is uninsured if they are not covered by the types of health insurance asked by the CPS. The Behavioral Risk Factor Surveillance System (BRFSS) also provides national and state estimates of the uninsured. However, the BRFSS does not ask about the insurance status of children. As a result, the uninsurance estimate provided by the BRFSS does not provide an estimate of the *entire*

[1] Minnesota Department of Health economics Program, "Characteristics and Trends Among Minnesota's Uninsured Population." Forthcoming Issue Paper.

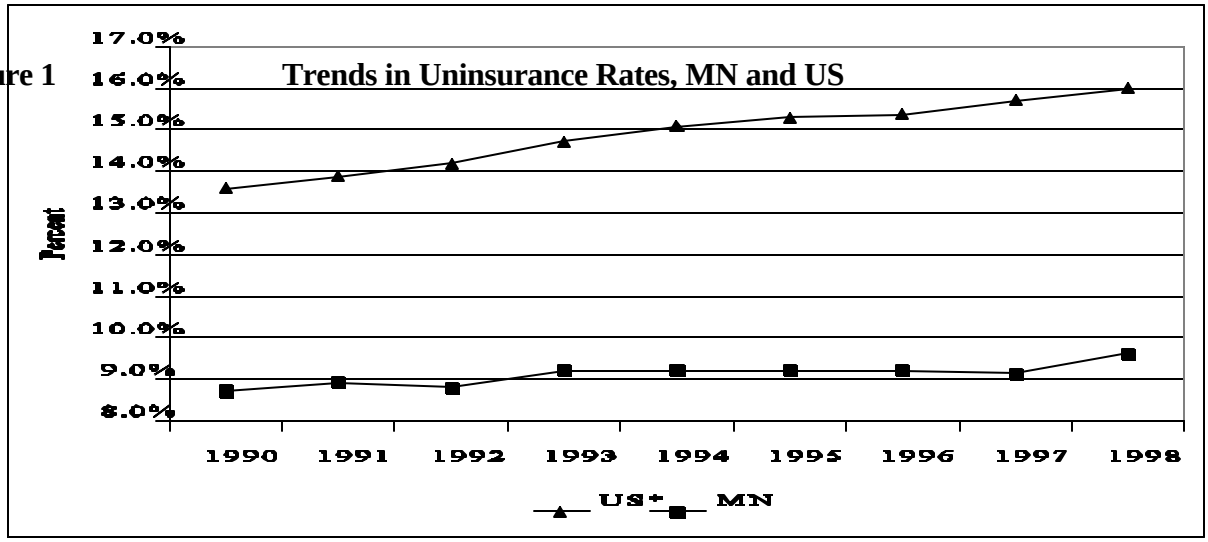
Minnesota population, but rather provides an estimate of the rate of uninsurance for adults over the age of 18.

Periodic studies are also conducted that provide information on the insurance status of Minnesotans. The National Survey of America's Families (NSAF) conducted by the Urban Institute in 1997 provides a ***point-in-time estimate*** of the rate of uninsurance in Minnesota, which means that the estimate of the uninsured is based on the insurance status of a person at the time of the survey as opposed to during the entire year as assessed by the CPS. The University of Minnesota Health Access Survey conducted in 1990, 1995, and 1999 provides whole-year, point-in-time, and intermittent estimates of the uninsured.[3] Periodic studies tend to have larger sample sizes and provide more in depth information; however, a drawback to these surveys is that they are unsuitable either for making national and state comparisons or for tracking year-to-year trends in the uninsured.

Trends in the Rate of Uninsurance in Minnesota

Minnesota's rate of uninsurance, as estimated in the CPS and shown in Figure 1, has remained steady at around 9% during the 1990s. In contrast, the nation's rate of uninsurance has increased from 13.6% in 1990 to 16% in 1998. The changes in the rate of uninsurance from 1990 to 1998 are not significant for Minnesota, but they are for the U.S. Although the University of Minnesota's Health Access Survey and the BRFSS report different rates of uninsurance for Minnesota, they reach the same conclusion as the CPS. ***Minnesota's rate of uninsurance has remained stable, while the nation's rate of uninsurance has increased over the last decade.***

Figure 1 **Trends in Uninsurance Rates, MN and US**



* Uninsurance rates for the US from 1990 to 1998 are statistically significant at the 90% confidence level.

The uninsurance rates for the US and MN are based on three-year averages of CPS estimates. Because of year-to-year fluctuations that occur in data collection and estimation, the Census Bureau recommends that CPS data be averaged over a three-year period when comparing the uninsurance rates of a given state to those of another state or region.

Characteristics of the Uninsured

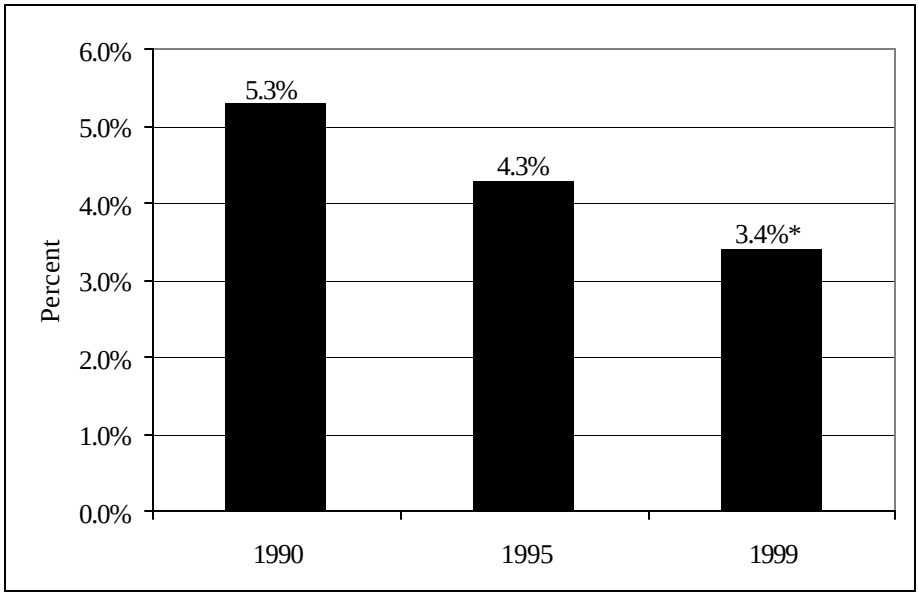
Although Minnesota's rate of uninsurance has remained stable since 1990, the demographic characteristics of the uninsured have changed from 1990 to 1999. Table 2 describes the current characteristics of the uninsured and compares the demographic composition of the uninsured from 1990 to 1999. Currently, the uninsured are most likely to be male (50.7%), be adults between the ages of 25 and 44 (42.4%), be white (83.4%), have incomes between 101% and 200% of the federal poverty level (37.6%), live in the Twin Cities metropolitan area (48.3%), be employed by someone else (55.2%), be single (41.2%), and have some college or technical school education (41.7%).

Several notable trends occurred among the uninsured population from 1990 to 1999. Statistically significant changes in the age, race, and income distributions of the uninsured occurred over this time period. Children made up a smaller proportion of the uninsured in 1999 (16.5%) than in 1990 (25%). Populations of color have an increased representation among the uninsured, rising from 5.6% in 1990 to 16.6% in 1999. The proportion of the uninsured with incomes below 200% of the federal poverty level dropped from 62.3% in 1990 to 47.7% in 1999 (table 2, page 4.)

Profile of Uninsured Children

Policymakers in Minnesota have placed particular emphasis on achieving universal access to health insurance coverage for children. From 1990 to 1999 the state of Minnesota succeeded in reducing the number of uninsured children. As shown in table 2, children made up a smaller proportion of the uninsured in 1999 (16.5%) than in 1990 (25%). In addition, figure 2 shows that the uninsurance rate for children decreased significantly from 1990 to 1999. Depending on the source, current estimates of the rate of uninsurance for children range from 3.4% to 5.5% or 42,000 to 68,000 children under 18.[4]

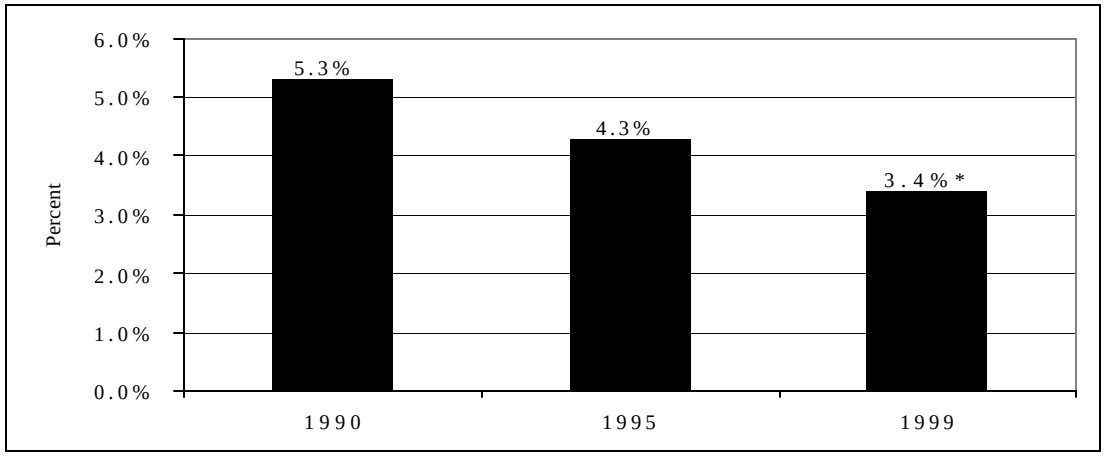
Figure 2 **Percent of Minnesota Children Uninsured**



Based on 1990-1999 University of Minnesota Health Access Survey data.
The percentages are based on point-in-time estimates of children ages 0 through 17.
* Significant difference from 1990 to 1999 at 90% confidence level.

TABLE 2: Demographic Characteristics of Minnesota's Uninsured Population

	1990	1995	1999



Gender			
	51.1%	55.2%	50.7%
Male	49.9%	44.7%	49.3%
Female			
Age			
0-5	6.1%	3.9%	3.9%
6-17	18.9%	14.3%	12.6%
18-24	19.9%	18.5%	23.1%
25-44	36.4%	46.0%*	42.4%
45-64	18.8%	17.2%	17.8%
Employment Status (adults)			
Self-employed	28.1%	24.4%	27.9%
Employed by someone else	51.4%	58.1%*	55.2%
Unemployed	17.3%	15.2%	15.4%
Retired	3.3%	2.2%	1.5%
Marital Status (adults)			
Single	41.5%	43.9%	41.2%
Married	42.4%	36.1%*	33.6%
Living with partner	N/A	12.1%	12.8%
Divorced/widowed/separated	16.0%	7.9%	12.5%
Race/Ethnicity			
White	94.4%	87.3%*	83.4%^
African American	3.2%	4.1%	7.5%^
American Indian/Alaskan	0.2%	2.5%*	2.1%*
Asian/Hmong/Pacific Islander	0.7%	1.2%	1.7%
Hispanic/Latino	1.2%	2.7%	2.7%
Other	0.1%	2.1%*	2.5%^
Education Level (adults)			
Less than high school	10.4%	10.1%	10.0%
High school degree	39.3%	36.6%	31.2%
Some college/tech school	38.6%	37.6%	41.7%
College graduate/Grad School/Beyond	11.7%	15.6%	17.2%
Geographic Region			
Twin Cities Metro	44.9%	55.3%*	48.3%
Other Metro	15.0%	11.8%	16.4%
Rural	40.1%	32.9%	35.3%

Income (as % of federal poverty guidelines)			
0%-100%	17.5%	11.8%	10.1%^
101%-200%	44.8%	33.3%*	37.6%
201%-300%	22.0%	27.3%	19.9%
301%-400%	8.9%	12.8%	10.5%
401% +	6.8%	14.6%*	21.9%^

Based on 1990-99 University of Minnesota Health Access Survey data.
The percentages are based on point-in time estimates of the uninsured.
* Significant difference from 1990 to 1995 at 90% confidence level.
^ Significant difference from 1990 to 1999 at 90% confidence level.

As shown in Table 3, uninsured children in Minnesota are most likely to be female (56.7%), be over the age of 6 (71.8%), be white (75.3%), belong to families with incomes below 200% of the federal poverty level (69.19%) and live with two parents (56.7%). (See table 3, page 6.)

There are at least two possible reasons for the decline in the uninsurance rate for children. The introduction and subsequent expansions of MinnesotaCare have helped to reduce the number of uninsured children. The MinnesotaCare program was created in 1992 to expand health care access to Minnesota's uninsured population through a publicly-subsidized health insurance plan. A University of Minnesota study published in 1997 concluded that the MinnesotaCare program had been successful in enrolling uninsured children.[5] Currently, 49,000 children ages 0 through 17 are enrolled in MinnesotaCare.[6]

Second, the decrease in the number of uninsured children may also be attributable to the rising incomes of Minnesota families. From 1990 to 1998, the inflation adjusted median household income in Minnesota increased by 22.1% while the median household income for the nation increased by only 4.1%.[7] This increase in household income may have helped families buy health insurance coverage for their children. From 1995 to 1999, the percentage of children enrolled in private group insurance plans increased significantly from 73.8% to 79%.[8]

Profile of Uninsured Populations of Color

Although Minnesota continues to report one of the lowest rates of uninsurance in the country, certain racial and ethnic populations in the state report higher rates of uninsurance (see figure 3, page 6).[9] As shown in table 2, representations of populations of color among the uninsured increased from 5.6% in 1990 to 16.6% in 1999. Although populations of color have increased in size since 1990, this increase does not fully explain the increase in their representation among the uninsured. Populations of color comprised 6.2% of Minnesota's population in 1990 and 8.4% of Minnesota's population in 1998.[10]

One of Minnesota's health goals is to eliminate disparities in health insurance status among racial and ethnic groups. To eliminate this disparity, the state must do more to understand the characteristics of

uninsured populations of color.

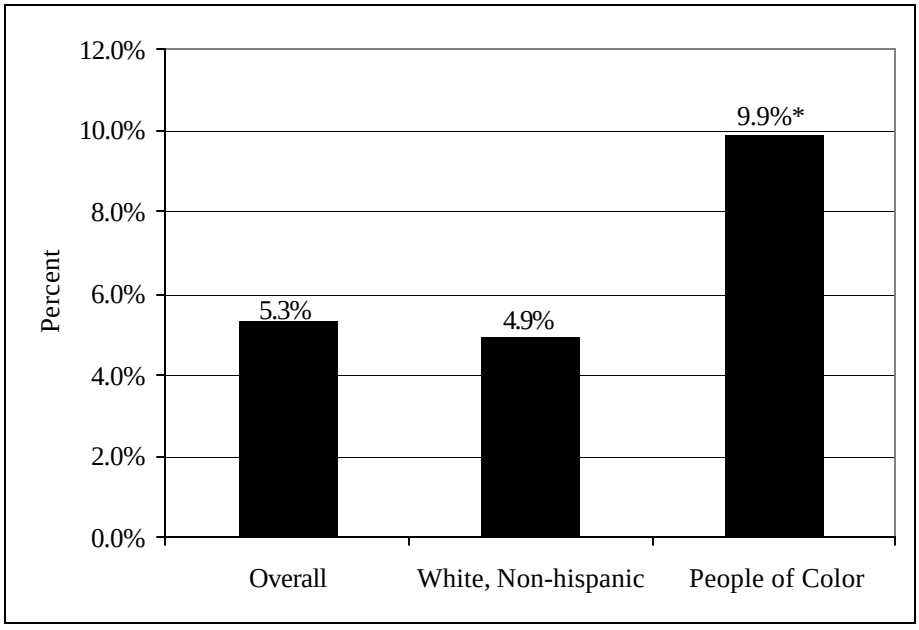
Table 3 **Characteristics of Uninsured Children in Minnesota**		
Sex	Male	43.4%
	Female	56.7%
Age	0 to 5	28.2%
	6 to 17	71.8%
Race/Ethnicity	White	75.3%
	Non-white	24.7%
Income As % of Poverty		
	0% to 200%	69.1%
	201%	30.9%
Living Arrangements		
	Two parents in household	56.7%
	One parent in household	43.3%

Based on the Urban Institute's 1997 National Survey of America's Families (NSAF) data.

* Based on 1999 University of Minnesota Health Access Survey data.

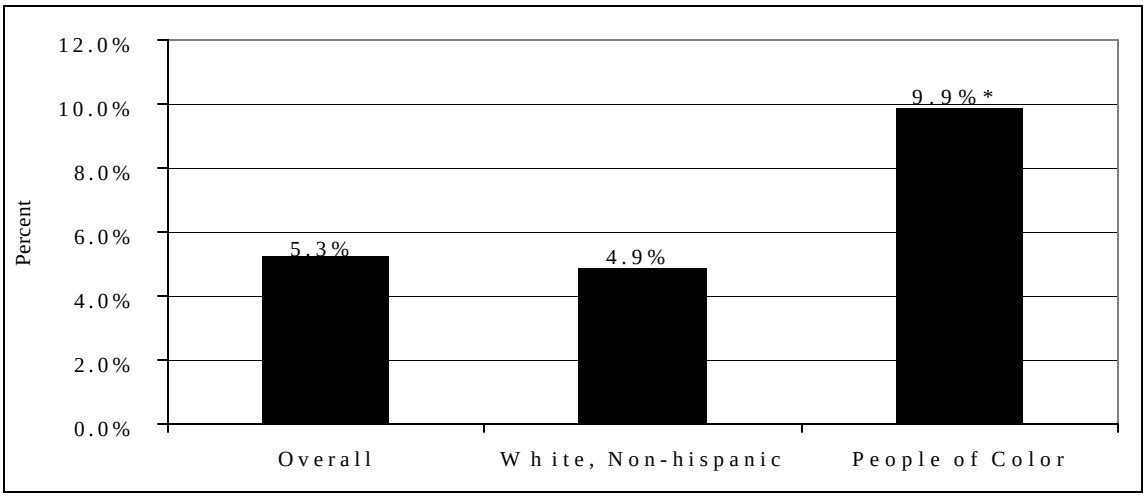
The percentages are based on point-in time estimates of uninsured children ages 0 through 17.

Figure 3 Uninsurance Rates by Race/Ethnicity, 1999



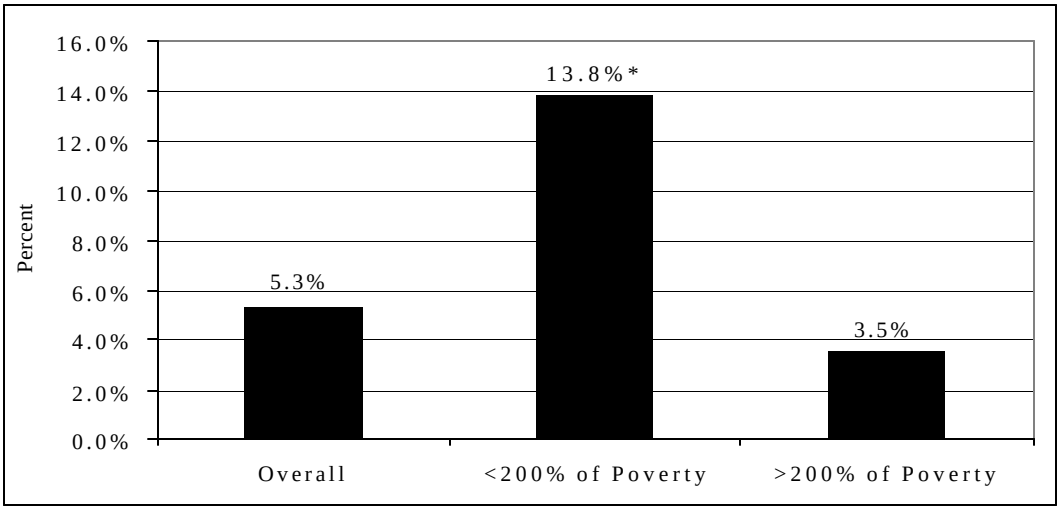
Based on 1999 University of Minnesota Health Access Survey data.
The percentages are based on point-in-time estimates.
* Significant difference from White, Non-Hispanic at 90% confidence level.

Profile of Low-Income Uninsured



Low-income people are at the greatest risk of being uninsured because they cannot afford to purchase insurance, do not work for an employer that offers health insurance, or are not eligible for employer-based coverage. Figure 4 shows that people with incomes below 200% of the federal poverty level are about four times more likely to be uninsured than people with incomes above 200% of the federal poverty level.

Figure 4 Low Income Uninsurance Rates



Based on 1999 University of Minnesota Health Access Survey data.
The percentages are based on point-in-time estimates.
* Significant difference from >200% of Poverty at 90% confidence level.

Although low-income people are more likely to be uninsured than high-income people, Minnesota has reduced the number of low-income uninsured. From 1990 to 1999, the proportion of the uninsured with incomes below 200% of the federal poverty level dropped from 62.3% to 47.7%. Part of the decline in the number of low-income uninsured is a result of the MinnesotaCare Program. Currently, 94,000 people or 85% of MinnesotaCare enrollees have incomes below 200% of the federal poverty level.[11] Without MinnesotaCare, a majority of low-income enrollees would go without health care coverage. A 1995 study reported that 88% of MinnesotaCare enrollees did not have access to employer-based insurance and that two-thirds would go without coverage if the program ended.[12]

The decrease in the proportion of the uninsured with incomes below 200% of the federal poverty level is also the result of economic prosperity. From 1990 to 1998, the inflation adjusted median household income in Minnesota increased by 22.1% and the percent of Minnesotans with incomes below the federal poverty level decreased from 12% to 10.4%.[13] Rising incomes and decreased poverty have likely contributed to the decline in the proportion of the uninsured with low-incomes.

There also appears to be geographic differences in the income levels of the uninsured. The low-income uninsured are more likely to live in a rural part of the state than the high-income uninsured. Data presented in table 4 suggest that there is still substantial opportunity to enroll people in MinnesotaCare in rural areas of the state. Approximately 45% of uninsured Minnesotans with low incomes live in rural areas, while only 35% of uninsured Minnesotans live in rural areas of the state (see table 2).

Table 4 Characteristics of the uninsured in Minnesota by Poverty Level

	< 200% of Poverty	> 200% of Poverty
Sex: Male	43.4%	56.8%
Female	56.2%	43.2%
Age: to 17	22.9%	12.7%
18 to 64	77.1%	87.3%
Race/Ethnicity: White	87.3%	92.1%
Populations of Color	12.7%	7.9%
Geographic Region		
Twin Cities Metro	36.0%*	56.1%
Other Metro	19.1%	14.0%
Rural	44.9%*	29.9%
Employment (Adults)		
Self-employed	23.2%	36.7%
Employed by Other	55.6%	52.6%
Unemployed	19.1%	10.2%
Retired	02.1%	00.6%
Marital Status (Adults)		
Single	35.1%	39.7%
Married	33.8%	35.3%
Living w/ partner	12.1%	16.3%
Divorced/widowed/se	19.0%*	8.7%
Educational Level (Adults)		
Less than High School	30.1%	20.8%
High school	26.9%	23.7%
Some college/tech	33.3%	36.1%
College Grad	9.7%	19.5%

Based on 1999 University of Minnesota Health Access Survey data.
The percentages are based on point-in time estimates of the uninsured.
* Significant difference from >200% of Poverty at 90% confidence level.

Availability of Health Insurance for the Uninsured

A large majority of the uninsured have access to employer-based coverage and/or MinnesotaCare. ***Approximately 73.5% of uninsured children in the state may qualify for MinnesotaCare based upon income and lack of access to employer-based coverage.*** Given this statistic, current programs appear to be in place to assure health insurance coverage for most of Minnesota's children. In total, 32% of uninsured Minnesotans do not have access to employer-based coverage or MinnesotaCare.

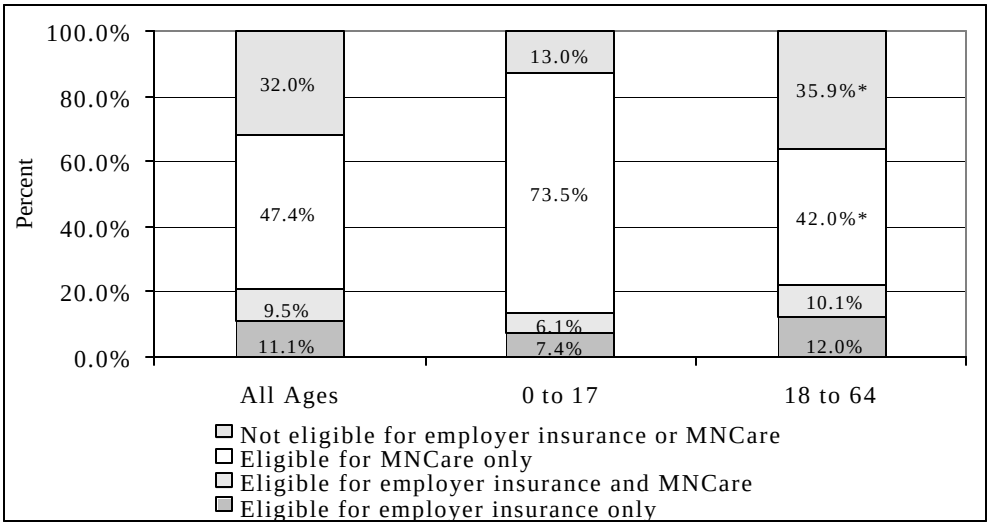


Figure 5 Availability of Private and Public Insurance for the Uninsured

Based on 1999 University of Minnesota Health Access Survey data.
The percentages are based on point-in-time estimates of the uninsured.
* Significant difference from age 0 through 17 at 90% confidence level.

Since most uninsured people in Minnesota either have access to employer-based coverage or potentially qualify for MinnesotaCare, it is important to understand why these people are uninsured. Of those who are eligible for employer-based coverage, 41.8% have incomes below 200% of the federal poverty level (see table 5, page 10). A recent national study also finds that approximately 20% of the uninsured have access to employer-based health insurance and that 75% of low-income uninsured workers cite cost as their main reason for declining employer coverage.[14] A large number of the uninsured with access to employer-based coverage may not be purchasing it because they cannot afford to pay their part of the premium. In addition, many of these people do not qualify for MinnesotaCare because they have access to employer-based coverage where their employer pays at least 50% of the premium.

Cost may be less of a barrier for most of the uninsured that are eligible for MinnesotaCare. In general, families and children with incomes below 275% of the federal poverty level and adults without children with incomes below 175% of the federal poverty level are eligible for MinnesotaCare. The MinnesotaCare program operates on a sliding fee scale. Those with higher incomes pay higher premiums. Of those who are eligible for MinnesotaCare, 84.4% have incomes below 200% of the federal poverty level which places them in the middle to lower part of the sliding fee scale for MinnesotaCare (see table 5, page 10). Additional data indicates the importance of continuing the outreach efforts for MinnesotaCare already undertaken by the Minnesota Department of Human Services. In 1999, only 56.2% of the uninsured who were eligible for MinnesotaCare had heard of or been given information about the program.[15]

Table 5 Characteristics of the Uninsured by Insurance Eligibility

	Employer	MNCare	Not Eligible
Overall	20.6%	47.4%	32.0%
Sex Male	45.4%	48.4%	54.3%
Female	54.6%	51.7%	45.7%
Age 0 to 17	11.3%	26.7%*	7.0%
18 to 54	88.8%	73.3%*	93.0%#
Race/Ethnicity White	84.3%	81.2%	93.3%#
Populations of Color	15.7%	18.8%	6.7%#
Income as % of Poverty			
0% to 200%	41.8%	84.4%*	8.8%#^
210% to 300%	22.4%	15.6%	25.1%
301% to 400%	17.6%	00.0%	20.3%
401% +	18.2%	00.0%	45.8%^
Geographic Region			
Twin Cities Metro	45.0%	40.6%	57.0%#
Other Metro	18.3%	19.6%	13.4%
Rural	36.7%	39.9%	29.6%

Based on 1999 University of Minnesota Health Access Survey data.

The percentages are based on point-in time estimates of the uninsured.

* Significant difference between Employer and MNCare at 90% confidence level.

Significant difference between MNCare and Not Eligible at 90% confidence level.

^ Significant difference between Employer and Not Eligible at 90% confidence level.

Conclusion

As policymakers search for ways to decrease the number of uninsured people in the state, several important facts should be remembered:

- In general, Minnesota's rate of uninsurance has remained stable in the 1990s, while the rate in the U. S. increased.
- The number of uninsured children has decreased since 1990 and 73.5% of children who are currently uninsured may qualify for MinnesotaCare.
- Populations of color report higher rates of uninsurance and their representation among the uninsured increased significantly from 1990 to1999.
- The low-income uninsured comprised a smaller proportion of the uninsured in 1999 than in 1990, but they are still at greater risk of being uninsured than higher income individuals.
- Approximately two-thirds of uninsured Minnesotans may already be eligible for some form of coverage, either employer-based health insurance coverage or MinnesotaCare.

Current surveys conducted in Minnesota do not provide large enough sample sizes to allow for an in-depth analysis of the uninsured. To adequately assess and monitor the health insurance status of certain populations in Minnesota, surveys with larger sample sizes for populations of color, rural residents, low-income people, children, and young adults are needed. An annual or biannual Minnesota-specific survey with a large sample size would assist the Minnesota Department of Health and others in monitoring the rate of uninsurance and analyzing the uninsured population. The Health Economics Program will continue to use available data to monitor the rate of uninsurance and report periodically on the characteristics and trends of uninsured Minnesotans.

Notes

1. According to the CPS, Minnesota's rate of uninsurance in 1998 was 9.6%. Only Hawaii (8.7%) and Wisconsin (9.4%) had lower rates. The Behavioral Risk Factor Surveillance System (BRFSS) reports Minnesota's rate of uninsurance for 1998 as 8.5%. Only Hawaii (5.9%), Delaware (8.0%), Nebraska (8.0%), and Wisconsin (8.3%) had lower rates.

2. Although the CPS is intended to provide whole-year estimates of the uninsured, many researchers contend that the CPS actually reflects a point-in-time estimate or a mix between the two estimates. See Lewis, K., Ellwood, M., & Czajka, J. L. (1998). Counting the Uninsured: A Review of the Literature. The Urban Institute.

3. Call, K. T., et al. (1999). Minnesota Health Access Survey 1999, Final Report. University of Minnesota School of Public Health, Division of Health Services Research and Policy.

4. The point-in-time estimate of 3.4% or 42,000 uninsured children under age 18 is based on 1999 University of Minnesota Health Access Survey data. The Urban Institute NSAF data show that 5.5% or 60,000 Minnesota children under age 18 were uninsured in 1997.

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6. Minnesota Department of Human Services, enrollment as of July 1999.

7. U.S. Census Bureau, Statistical Abstract of the United States, 1999.

8. Based on 1996-1999 University of Minnesota Health Access Survey data.

9. The same sample sizes for populations of color were too small to report uninsurance rates for specific racial or ethnic populations.

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13. U. S. Census Bureau, Statistical Abtract of the United States, 1999.

14. Cunningham, P. J., Schaefer, E. & Hogan, C. (1999). Who Declines Employer-Sponsored Health Insurance and is Uninsured? Center for Studying Health System Change, Issue Brief #22.

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